In N.C., Improving Worker Health -- and Cutting Costs

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ASHEVILLE, N.C. -- When Bill Wilmer was diagnosed with diabetes 10 years ago, he didn't have the time or money to fight the deadly disease. Besides, Wilmer figured, with no cure in sight, why bother pricking himself with a syringe several times a day?

"I didn't think it made much difference, so I decided to do it my way -- like Frank Sinatra," he explained.

Today, the 65-year-old retiree is a model patient. His health has improved, he meets religiously each month with his pharmacist, and instead of quoting the Rat Packer, he's singing a new tune. "An ounce of prevention is worth a pound of cure," he said, sounding more like a schoolmarm than a former backhoe operator.

While federal and state lawmakers are struggling to find ways to control rising health care costs, this small city tucked between the Blue Ridge and Great Smoky Mountains has found a way to save thousands of dollars and improve the health of its employees. Unlike academic theories and political rhetoric, the six-year-old Asheville Project offers real-life lessons on the great potential -- and limitations -- of an approach known as disease management.

Built on the philosophy that better health leads to lower medical costs, the Asheville Project uses financial incentives to link highly trained pharmacists to city workers who have diabetes, hypertension, asthma or high cholesterol -- all expensive chronic illnesses. In a highly unusual arrangement, pharmacists are paid to counsel patients, offering advice on diet, exercise, stress reduction and medications. With the monthly sessions, pharmacists help patients stay on track and act as a bridge to physicians.

To lure employees such as Wilmer, the city made an irresistible offer: If he agreed to attend a health class and check in with pharmacist Beth DeWitt once a month, the city would give him

free medications and supplies such as the glucose meter and test strips to monitor his blood sugar.

It wasn't altruism that prompted the city's generosity; it was savvy investing. "I'm getting a 4-to-1 return on my investment," said John Miall, the risk manager who approved the counterintuitive solution to soaring medical bills.

By hiring pharmacists to serve as coach-cheerleader for employees with chronic illnesses, the city has drastically reduced emergency procedures and complications caused by prescription misuse. Although drug costs rose, total health care spending on diabetics fell from $7,042 per patient in 1996 to about $4,000 apiece each year since the program began, in 1997.

What Miall spent for prescriptions, pharmacist payments and even additional doctor visits, he more than made up in reduced hospital visits, kidney dialysis and transplants. "I can afford a lot more medications and physician visits than I can trips to the emergency room," he said.

Absenteeism rates for participants fell from an average of 12.6 sick days a year to six, said city finance director Bill Schaefer. "Just having the people at work is a wonderful return on the dollar," not to mention the intangible benefits of healthier workers on the job, he said.

Yet many analysts caution that it will be difficult for larger companies and cities to replicate the creativity of this tightknit, progressive community or to expand disease management to numerous illnesses simultaneously. As many in Asheville can attest, it is not easy to shift responsibility -- and money -- to a new group of medical providers.

Doctors, including the president of the American Medical Association, have expressed skepticism about expanding the clinical duties of pharmacists, nurses or emergency medical technicians. Many physicians fear a loss of business or authority. Insurers have shown little willingness to reimburse pharmacists and other non-physician caregivers for the "cognitive services" or counseling that leads to better-informed, healthier patients.

Bob Burgin, president and chief executive of Mission St. Joseph's Health Care System here, said he initially worried about a decline in business if the city's program worked. But reducing emergency room demands has freed staff and beds for more lucrative procedures, such as hip replacements, angioplasty and other services targeted to aging baby boomers.

Finally, even the most successful disease management program is unlikely to solve what is becoming a cost crisis in America's health care system. "We're doing what we can to control costs, but we're scratching at the margins," Schaefer said.

Yet the success of the Asheville Project is winning converts. Blue Ridge Paper has begun enrolling hundreds of employees at its seven plants. Burgin was so impressed he adopted the program for his 5,000 workers and their 3,900 family members. Empowering patients, tapping underutilized medical professionals such as pharmacists, and reimbursing wellness instead of illnesses "is the only hope of controlling health care costs in the long term," he said.

Diabetes, in which the body has difficulty processing sugar, is a classic example, said Frank Vinocur, director of the diabetes division at the Centers for Disease Control and Prevention. About 17 million Americans have diabetes, and an additional 1 million cases are expected this year.

The medical and financial toll is enormous. Diabetes is the fifth-deadliest disease in the nation today, and the leading cause of blindness, kidney failure and amputations. In 1997, researchers put the annual cost of diabetes at $100 billion. Vinocur expects that to double or triple by 2025.

Although there is no cure, modest lifestyle changes, coupled with medical advances, make it possible for diabetics to live longer, more productive lives, said endocrinologist Jeff Russell. That is why Russell and hospital pharmacist Barry Bunting, coordinator of the Asheville Project, put diabetes at the top of the target list for disease management.

For many in the program, simple tips, financial assistance and a sense that someone cares has meant a remarkable improvement in their quality of life.

Patricia Ezzel, 51, said the city picked up her $250 in annual co-payments. But she no longer disappears from her job in human resources because of dizzy spells, elevated blood pressure and other ailments. And she learned that her favorite grapefruit juice makes it difficult for her liver to absorb blood pressure medicine.

Like Wilmer, Harry McDaniels was in denial about his diabetes and refused to pay $45 a month on test strips to check his blood sugar with a glucose meter.

"This program helped me come out of the closet," he said. The health classes revealed he was far from alone, and the tough love he gets from his pharmacist strikes just the right tone. "He'll say, 'Harry, let's control this, or your wife won't be seeing you anymore,' " McDaniels said. The monthly visits are key, he said, because "the meter's not going to lie."

Miall tapped pharmacists because they are convenient, available and "have an incredible knowledge of medication," he said. Bringing in pharmacists also helps reduce the $177 billion spent annually because of misuse of medications, said Crystal Wright, spokeswoman for the National Association of Chain Drug Stores.

For pharmacists, it is an opportunity to use some of the expertise developed over six years in school and to make about $40 a month for each patient they counsel. During an average shift at Eckerd, Amy Lugo said, she filled 350 to 500 prescriptions, and "most of the questions I got were, 'Where's the toilet paper?' "

Because of pharmacist intervention, 60 percent of patients in the diabetes program now take ACE inhibitors to help protect the kidneys, compared with none six years ago. McDaniels and Wilmer credit their pharmacists with recommending an aspirin a day for their hearts. In medical terms, the results are impressive, said Carol Cranor, a pharmacist who analyzed the Asheville data for the University of North Carolina.

Measurements of LDL, or "bad" cholesterol, and Hemoglobin A1c, or average blood-sugar levels, have fallen well below targets set by the American Diabetes Association. Regular eye and foot exams, central to diabetes care, are up, while smoking has been cut in half in the group.

In recent years, the city, hospital and Blue Ridge Paper have expanded the program to asthma, hypertension and high cholesterol, all of which benefit from early intervention. Officials say the medical and financial payoffs will likely come later, because it can take years or decades for heart disease to manifest itself.

Many patients, such as R. Patricia Leckey, enroll in several programs. A single woman who supports her elderly mother, Leckey has diabetes, asthma and high blood pressure, maladies that were costing her about $450 a month out-of-pocket. "I'm a triple whammy," she said, chuckling.

Working with pharmacist Bill Horton, Leckey walks more, passes up fast food and monitors her asthma with a machine that measures breathing capacity. She has not been to a doctor in four months and has not purchased an inhaler -- once a monthly expenditure -- in just as long.

For retired arson investigator Harley Shuford, the pharmacy sessions are a chance to get all his questions answered in layman's terms and to monitor his own health progress.

"In a nutshell," he said, "what it means for city employees is this gives you the knowledge, the equipment and incentive to control your own destiny."

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Pharmacist oversight cuts cost of chronic diseases

By MICHAEL PRINCE
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ASHVILLE, N.C.-A novel disease management program begun by a North Carolina city is now going national.

The program-dubbed the Asheville Project-has slashed medical costs for participants with, for example, diabetes by more than 25% on average, with larger savings over time.

Many employers now are turning their attention to the experience of Asheville, N.C., and with good reason. Since 1997, when the disease management program was launched to improve the health of a few hundred city workers with four chronic diseases-diabetes, asthma, hypertension and high cholesterol-the city has saved thousands of dollars in medical expenses.

Capitalizing on the project's success, five employers around the country now are participating in recently launched pilot programs based on the Asheville Project.

Besides the potential for savings on medical expenses for chronic diseases, employers are attracted to the unique way the project operates. The program relies on specially trained pharmacists to monitor participants.

Patients agree to monthly meetings with the pharmacists, who sign up to participate in the program and undergo specialized training. These regular meetings are designed to ensure the patients are taking their medications and are maintaining their health. In addition, basic physical exams are conducted. These monthly sessions help the patients stay on track in controlling their disease. If the pharmacists find a health problem, they immediately schedule the patient an appointment with his or her physician.

This constant monitoring catches small problems before they become big ones. The result of maintaining better health is fewer hospitalizations, lower costs and reduced absenteeism.

To induce patients into the program, the city waived all copayments for the pharmacist visits, drugs for their disease and other supplies. For example, diabetic patients pay nothing for their insulin and also receive a machine that measures blood sugar levels. The city, which is self-insured, foots the entire bill.

The city pays the pharmacists an average of $38 per visit, said John Miall Jr., director of risk management for Asheville, who is one of the founders of the project. "That's a pretty cheap office visit," he noted.

If a patient fails to stick with the program or misses too many meetings with the pharmacist, he or she is removed from the program and has to start paying copayments again, Mr. Miall said.

"Whether you need it or not, you go to your appointment," he said.

The savings have been considerable, according to recently published studies about the program.

The city has saved about $2,000 in health care spending per year per patient in the diabetes program, said Barry Bunting, clinical manager of pharmacy at Mission St. Joseph's Health System in Asheville, and coordinator of the project.

On average, a patient with diabetes incurred $7,082 in medical expenses in the year before entering the program, Mr. Bunting said. This dropped 26% to $5,210 in the first year of the program and fell 34% to $4,651 for those in the program for five years.

In fact, the program was so promising from the start that the hospital adopted it in 1998 for its own employees, he said.

The big savings for Asheville have come from reduced hospital costs, according to Mr. Bunting. Because the patients with chronic diseases are kept healthier, they incur fewer emergency room visits and hospital stays, he said.

"The big losers in this whole scheme are the hospitals. Because the hospital is not admitting those patients" whose diseases are not controlled, said Dr. Paul Martin, medical director of health services for Asheville and the medical director of staff health services at Mission St. Joseph's.

The unique feature of paying for regular pharmacist visits helps patients with chronic problems maintain their health, said Bruce Kelly, senior consultant at Watson Wyatt Worldwide in Minneapolis.

"Our medical care system pays a premium for therapy and not for prevention or coaching very much," he said.

Asheville's Mr. Miall estimates that the city has saved $4 for every $1 it has spent on employees in the program. Besides the lower costs, the number of sick days for people in the program have dropped by more than 50%, he said. Patients in the program averaged more than 12 sick days in the year before entering the program and fewer than six while enrolled, he said.

Word of the program's success rapidly spread throughout the Asheville region.

"Several companies have either implemented that model for their own employee population or are planning to do it," said Michael McManus, executive director of the WNC Health Coalition in Asheville.

"We look at it as a true pioneering effort by the city of Asheville," he said.

One area employer adopting the program is Blue Ridge Paper Products Inc. in nearby Canton, N.C., said Jessica Ellis, manager of disability programs for the paper products maker.

Blue Ridge launched its program in 2001 for workers in seven states, she said. To date, about 150 people have enrolled, she said.

"If it wasn't for the Asheville Project, I wouldn't have known where to start," she said.

The zero copayment, she said, has been the key in attracting people to the program, she said.

Two aspects of the project make it likely to succeed, said Dr. Arnold Milstein, national health care thought leader at Mercer Human Resource Consulting in San Francisco.

By using the pharmacists, which are an established health care network, the costs for starting and maintaining the program are much lower than traditional disease management programs, he said.

Also, because patients have face-to-face meetings with the same pharmacists, a trusting relationship develops. "You substantially increase the potential of the patient taking to heart and adopting what the pharmacist advises," he said.

The pharmacists' role is seen as the key to the project's success, agreed Dr. Martin of Mission St. Joseph's.

"Pharmacists are ideal monitors," he said. They are well trained and geographically dispersed, he said. "It's convenient, it's accessible and it's an untapped resource."

Because of its success, the American Pharmacists Assn. Foundation has chosen the Asheville Project as a model for five pilot projects launched around the country earlier this year, said Dan Garrett, senior director of the foundation in Greensboro, N.C., and one of the founders of the Asheville Project.

The five pilot programs, which focus solely on diabetes patients, seek to replicate the Asheville Project with various employers. The pharmacists' group sees this as the first step in a wider introduction of the program, he said.

The pilot programs seek to determine the amount of money employers can save, the impact on employees' health and the best ways to administer the program, Mr. Garrett said. After the one-year pilots conclude, he said the foundation expects to be able to assist any employer in setting up its own program.

One of the employers in a pilot program, VF Corp., was attracted to the program because "the traditional ways of controlling health care costs are just not working anymore," said Debbie Arnold, manager of benefits planning at VF in Greensboro.

About 70 employees have already signed up for the program, she said. And while it's too early to determine any savings, the early responses from employees have been outstanding, she said.

To inform its employees of the new program, VF sent all employees at the participating locations a special announcement last year. Other communications followed, leading to a December meeting where questions could be answered in person and people could enroll, Ms. Arnold said.

Whether Asheville's approach ever moves into the mainstream is anyone's guess. Mr. Miall predicted that it won't happen until health insurers and medical stop-loss insurers see the savings it can generate and widely promote it to their employer clients.

Mr. Kelly of Watson Wyatt agrees. Since most employers rely on their health insurer or a disease management vendor for this type of program, employers won't adopt it until these vendors offer it, he said.

But others are more optimistic.

Mission St. Joseph's Dr. Martin said that other employers could easily adopt similar programs.

"The basic premises can be replicated in a variety of settings," he said.

And Ms. Arnold of VF said that with health care costs skyrocketing, now is a great opportunity to present a unique health care program to senior management. "They are open to new ideas," she said.